THE MEDICARE HANDBOOK

Including Official Information for Beneficiaries On

- Medicare Benefits
- New Provisions Under the Medicare Catastrophic Coverage Act of 1988
- Participating Physicians and Suppliers
- Health Insurance to Supplement Medicare
- Limits to Medicare Coverage

1989

Many doctors and suppliers have agreed to be part of Medicare's participating physician and supplier program. They accept assignment on all Medicare claims. If you get your medical services from one of these participating doctors or suppliers, you can often save time and money. See page 19 for more information about the assignment method of payment, and what you can do to find a participating doctor or supplier.

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SUMMARY OF NEW BENEFITS UNDER THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

Medicare has been changed to protect you better from major or "catastrophic" hospital, doctor and prescription drug expenses. The changes, mandated by the Medicare Catastrophic Coverage Act of 1988, are being introduced beginning January 1, 1989. Changes that will limit the amount you as a Medicare beneficiary must pay for inpatient hospital and skilled nursing facility care, as well as improve the skilled nursing facility and hospice benefit under Medicare, will begin in 1989. Other changes—limiting what you must pay for physician services and medical supplies, providing new coverage for preventive breast cancer screening, respite care and certain prescription drugs, and improving your home health benefit—will take effect on January 1, 1990. An expanded prescription drug benefit will begin on January 1, 1991.

The hospital, skilled nursing facility and hospice benefits described in this handbook include changes made by the new law.

A brief explanation of these new catastrophic benefit changes follows. Please note the date that each change becomes effective.

Your New Hospital Insurance Benefits

Most new Medicare hospital insurance benefits (Part A) begin January 1, 1989. You will be entitled to unlimited hospitalization for approved care after you pay a single annual deductible. There are no more "benefit periods," coinsurance payments, or "reserve days" for hospital care. Your skilled nursing facility benefit has also improved. You can have up to 150 days of care with no previous hospital stay. Hospice care has improved, too. You can now have an unlimited number of days of hospice care. These new benefits are fully described in this handbook.

Beginning January 1, 1990, your home health care benefit will be improved. If you qualify, reasonable and necessary skilled nursing care and home health aide care will be available to you for up to six days a week, as long as it is prescribed by a doctor. If you temporarily need home health care seven days a week, you can receive up to 38 consecutive days of care. The 38-day limit can be extended for a period of time under special circumstances.

Your New Medical Insurance Benefits

Beginning January 1, 1990, doctor and other outpatient services benefits under Medicare supplementary medical insurance (Part B) will be improved. In 1990, your share of approved charges for services and supplies covered by medical insurance will be limited to $1,370 (this limit will increase annually). You will continue to be required to pay for the first $75 (deductible) of charges approved by Medicare and 20 percent of all approved charges after that until these out-of-pocket expenses total $1,370. It does not matter whether these expenses are paid directly by you or by your private insurance company. Once the $1,370 amount is reached, Medicare will pay 100 percent of all other approved charges for most services under medical insurance for the remainder of the calendar year.

If a doctor or medical supplier does not accept assignment of your Medicare benefits and charges more than Medicare's approved charge, you must pay the difference and the payment will not count toward your $1,370 limit. Also, you will continue to be responsible for charges by physicians and suppliers who do not accept assignment over what Medicare allows, even after you reach the $1,370 out-of-pocket limit.

Beginning January 1, 1990, you will have a new home respite care benefit. This new benefit pays for the temporary services in the home for a home health aide to provide relief to an individual who lives with and normally helps a Medicare beneficiary who requires assistance with essential daily personal care. Medicare will pay for up to 80 hours per year of home health aide care, nursing care provided by a licensed professional nurse, and personal care services. You can use this

benefit only if you are chronically dependent and have met either the supplementary medical insurance catastrophic limit for the year ($1,370 in 1990) or the annual deductible for outpatient prescription drugs (which will be discussed later).

Beginning January 1, 1990, Medicare will help pay for mammography screening—a test which can detect breast cancer. Women 65 or older can use the benefit for a mammogram every other year, while certain younger disabled women covered by Medicare can use it for more frequent examinations.

Medicare already pays for prescription drugs when you are an inpatient in the hospital. **Beginning January 1, 1990,** the benefit will be expanded to cover a few outpatient prescription drugs in certain circumstances, and **in 1991, Medicare will cover most prescription drugs as well as insulin.**

In 1990, Medicare will help pay for certain drugs that are injected into the veins (intravenously) and can be safely used at home. In 1990, you will have to pay the $550 drug deductible (unless your drug treatment was begun in the hospital) for covered home intravenous drugs. Medicare will then pay 80 percent of the Medicare approved charges for intravenous drugs provided at home. In years after 1990, the deductible will be the same as that applying to all other prescription drugs.

Medicare already pays 80 percent of the approved charges for prescription drugs used in immunosuppressive therapy if the drugs are furnished within the first year following a Medicare-covered organ transplant. This first year coverage at 80 percent will continue during 1989 and years following, with no drug deductible. In the case of these drugs, the regular medical insurance $75 deductible applies only during 1989.

Starting in 1990, Medicare also will cover prescription drugs used in immunosuppressive therapy for other than first-year post-transplant use. During 1990, Medicare will pay 50 percent of the approved charges after you have paid the $550 deductible. In years after 1990, the drug deductible will be the same as that applying to all other prescription drugs; and the amount Medicare will pay will increase from 50 percent to the percentage applying to all other prescription drugs. (See explanation of coverage of all prescription drugs below).

Effective January 1, 1991, Medicare will cover most other prescription drugs as well as insulin. You will be responsible for an annual deductible and coinsurance payments. In 1991, the deductible will be $600 and the coinsurance 50 percent. This means that after you pay the first $600 for covered outpatient prescription drugs, Medicare will pay half of all other allowed drug charges for the remainder of the calendar year. In 1992 the deductible will be $652 and the coinsurance payment 40 percent of allowed charges. The deductible for 1993 is yet to be set.

NOTE: If you are a member of a Health Maintenance Organization or Competitive Medical Plan, you will get the new catastrophic benefits through your health plan.

PAYING FOR THE NEW CATASTROPHIC BENEFITS

These new catastrophic benefits will be financed by an increase in your monthly supplementary medical insurance premium and by an annual supplemental premium that will depend on your Federal income tax liability.

The Monthly Medical Insurance Premium

In 1989, $4 will be added to your monthly supplementary medical insurance premium to cover the cost of some of these catastrophic benefits. (If you reside in Puerto Rico, this additional premium amount will be $1.30 instead of $4.00; if you reside in the U.S. Trust Territories, the additional premium amount will be $2.10.) The basic premium amount for 1989, not including this $4 to help pay for new benefits, is $27.90.

NOTE: State Medicaid programs may be able to pay your Medicare premiums, if your income is below the poverty line. If you think that you may qualify for this benefit, please contact your State or local social service, welfare, or public health agency.

The Annual Supplemental Premium

Beginning in 1989, if you are eligible to receive hospital insurance (Part A), based on your work record or that of your spouse, you may have to pay a yearly supplemental premium.

If you do not know whether you are eligible for Medicare Part A, you can check with your local Social Security office.

The supplemental premium will be administered through the Federal income tax system. You will receive information about how to compute the premium amount from the Internal Revenue Service in your 1989 tax package. The following explanation of the new tax liability was prepared for Medicare by the Internal Revenue Service:

Explanation Of The New Tax Liability For Individuals Eligible For Medicare

Beginning in 1989, individuals eligible for Medicare Part A may owe a supplemental Medicare premium to help pay the cost of the new Medicare coverage for catastrophic expenses and prescription drugs. Individuals who are eligible for Medicare for more than 6 full months of the tax year will owe the supplemental premium if their adjusted Federal income tax liability is at least $150. Generally, the supplemental premium for 1989 is $22.50 for every $150 of adjusted Federal income tax liability. The maximum premium is $800 ($1,600 for certain married individuals).

Special rules apply to married individuals. If only one spouse is eligible for Medicare for more than 6 full months during the tax year and the couple files a joint return, the income tax liability for the Medicare-eligible spouse is one-half of the joint tax liability and the maximum premium is $800. If both spouses are eligible for Medicare and the couple files a joint return, the premium is figured as if the couple were one individual, but the maximum premium is $1,600 instead of $800.

A married individual filing a separate return, who lived with his or her spouse during the tax year, is treated as Medicare-eligible for more than 6 full months during the tax year if either the individual or the spouse was so eligible.

If you receive social security benefits, your Form SSA-1099, "Social Security Benefit Statement," will indicate whether you are eligible for Medicare. IRS Form 1040-ES, "Estimated Tax for Individuals," and IRS Form W-4P, "Withholding Certificate for Pension or Annuity Payments," may be used to prepay your premium so that you will not have to pay it all at one time when you file your tax return for 1989. For a complete explanation of the premium, you may want to obtain free IRS Publication 934, "Supplemental Medicare Premium," which will be available starting January 1989. You can get IRS forms and publications by calling the IRS toll-free number at 1-800-424-3676.

The IRS has an automated service called Tele-Tax which provides recorded tax information and is toll-free. Beginning January 2, 1989, taxpayers may request information on the supplemental Medicare premium requirement. Taxpayers should contact the system by calling 1-800-554-4477 and select topic number 223, "Social Security, Tier 1, and Catastrophic Coverage."

In addition, during the filing season the Tax Counseling for the Elderly (TCE) Program, provides free tax assistance to taxpayers who are 60 or older. Taxpayers interested in this service should call the toll-free telephone assistance number listed in the "U.S. Government" section of their local telephone directory under "Internal Revenue Service" and ask for the nearest TCE assistance site available.

Of course taxpayers can call the IRS toll-free telephone service year-round with questions on the Supplemental Medicare Premium. The service is available in all 50 States, the District of Columbia, Puerto Rico and the Virgin Islands.

Through this toll-free system you can get answers to your tax questions and pay only local charges, with no long distance charge to make your call. Toll-free numbers for your area are listed in the "U.S. Government" section of your local telephone directory under "Internal Revenue Service."

USING YOUR MEDICARE HANDBOOK

This section tells you about:

Your Medicare handbook is designed to help you determine if the services you need are covered by Medicare and how program payments are made. It is intended to be a handy reference to help you understand how the Medicare program works and to know what your benefits are. There is an alphabetical index at the back to assist you in finding information on specific subjects. While Medicare pays for many of your health care expenses, **it does not cover all of them.** Therefore, it is important for you to know in advance what Medicare does and does not pay for.

Handbook Highlights

- Page 22 provides a list of the services and supplies that Medicare cannot pay for.
- Page 24 tells you how to submit your medical insurance claims.
- Beginning on page 33, there is an address list showing you where to send your medical insurance claims.
- Page 20 tells you what to do if you disagree with a Medicare decision or the amount of payment on a claim.

If you have questions not answered by this handbook or would like additional information, you may call your Medicare carrier. Telephone numbers are listed on pages 33 to 37 of this handbook. Or you may call your Social Security office.

People eligible for Medicare because of kidney disease should ask for a copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*.

WHAT IS MEDICARE?

The Medicare program is a Federal health insurance program for people 65 or older and certain disabled people. It is run by the Health Care Financing Administration of the U.S. Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program.

The Two Parts of Medicare

There are two parts to the Medicare program. **Hospital Insurance** (Part A) helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care, and hospice care. **Medical Insurance** (Part B) helps pay for medically necessary doctors' services, outpatient hospital services, home health care, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare.

Both parts of Medicare have amounts that you must pay out-of-pocket (premiums, deductibles, coinsurance payments) or through coverage by another insurance plan. These out-of-pocket amounts are set each year, according to formulas established by Congress. New payment amounts begin each January 1. When amounts increase, you will be notified.

Intermediaries and Carriers

The Federal government contracts with private insurance organizations called **intermediaries** and **carriers** to make Medicare payments. **Intermediaries** make coverage and payment decisions on services in hospitals, skilled nursing facilities, home health agencies and hospices. **Carriers** handle claims for services by doctors and other suppliers covered under Medicare's medical insurance program.

Peer Review Organizations

Peer Review Organizations (PROs) are groups of practicing doctors and other health care professionals who are paid by the Federal government to review the hospital care

of Medicare patients. Each State has a PRO to help Medicare decide whether care is reasonable and necessary, is provided in the appropriate setting, and meets the standards of quality accepted by the medical profession. PROs have the authority to deny payments if care is not medically necessary or not delivered in the most appropriate setting. In addition, PROs respond to requests for review of hospital notices of noncoverage issued to beneficiaries; and PROs respond to hospital requests for reconsideration of PRO decisions. PROs also investigate individual patient complaints. If you are admitted to a Medicare participating hospital, you will receive ***An Important Message From Medicare*** which explains your right as a hospital patient and provides the name, address, and phone number of the PRO for your State. A copy of the message is printed on page 31.

If you feel that you are improperly refused admission to a hospital or that you are forced to leave the hospital too soon, ask for a written explanation of the decision. Medicare regulations require that such a written notice must fully explain how you can appeal the decision and it must give you the name, address, and phone number of the Peer Review Organization where your appeal or your request for review can be submitted. (See page 20 for a more complete discussion of your appeal rights under Medicare.)

Providers of Services and Suppliers

Providers of services and certain suppliers under Medicare must meet all licensing requirements of State or local health authorities. They must also meet additional Medicare requirements before payments can be made for their services. Medicare providers must also comply with Title VI of the Civil Rights Act which prohibits discrimination because of race, color, or national origin. Your Social Security office can tell you if the provider is Medicare certified.

Medicare cannot pay for care you receive from a hospital, skilled nursing facility, home health agency, hospice, or outpatient rehabilitation provider that is not certified to participate in the program. Such providers are referred to as non-participating. Certain suppliers of services, too, must be Medicare approved for Medicare to pay for their services. Medicare cannot pay for care you receive from the following suppliers unless they are certified: ambulatory surgical centers, independent physical therapists, independent occupational therapists, clinical laboratories, portable X-ray suppliers, dialysis facilities, and rural health clinics.

In some cases, Medicare **can** help pay for emergency care in a qualified non-participating hospital. If you need assistance any Social Security office can help you file the claim.

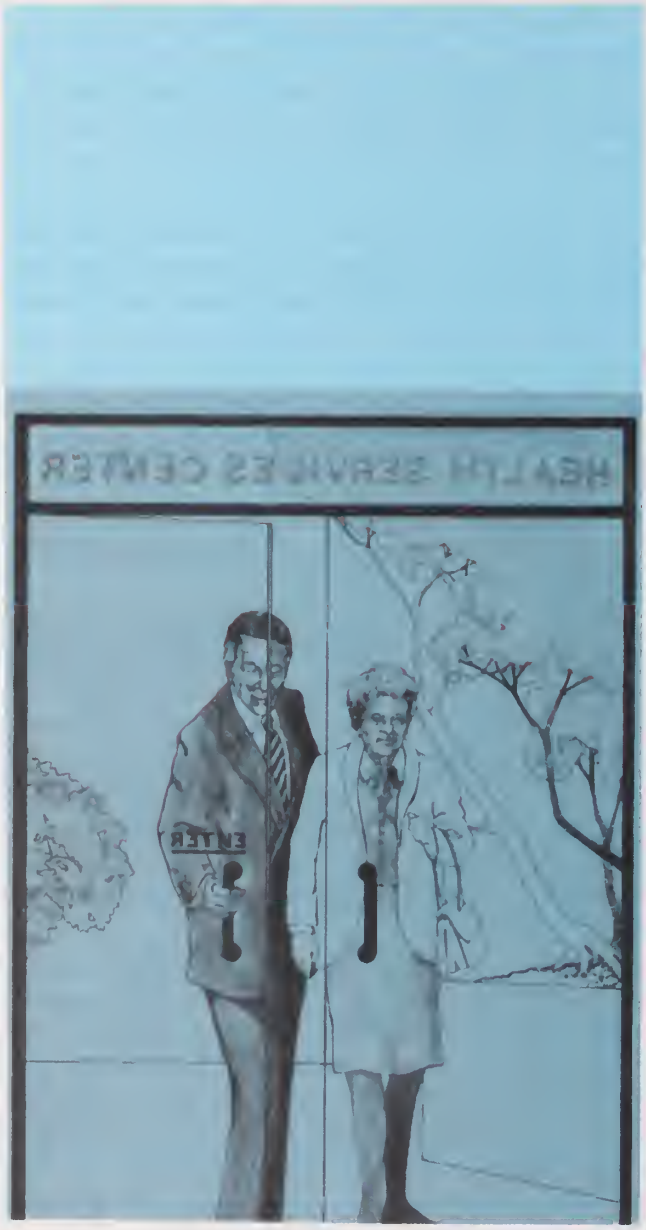
THE PRIVATE HEALTH PLAN OPTION

In addition to the traditional fee-for-service Medicare option, Medicare offers the Private Health Plan Option. Under this arrangement, many prepayment plans such as health maintenance organizations (HMOs) and competitive medical plans (CMPs) have contracts with Medicare. These plans receive direct payments from Medicare for services covered by both hospital insurance (Part A) and medical insurance (Part B).

HMOs and CMPs generally cover most of your health care costs, with fixed monthly premiums and minimal copayments. Many of them offer additional services beyond what Medicare covers at no additional cost: such things as preventive care, dental care, hearing aids and eyeglasses. HMOs and CMPs also reduce the amount of paperwork you have because you generally do not have to file any claims.

If you are thinking about choosing an HMO or CMP, there are some requirements and restrictions that you must consider. (1) You must be enrolled in Medicare's medical insurance (Part B) and continue to pay your Part B premium. (2) You must live within the geographic area which is served by the HMO or CMP under Medicare contract. (3) If you have elected hospice care, you are ineligible to enroll in an HMO or CMP as long as the hospice election remains in effect. However, after you become a member of an HMO or CMP, you may elect to receive hospice

benefits; you will not be required to disenroll from the HMO or CMP. (4) If you have end-stage renal disease, you are not allowed to enroll in an HMO or CMP. However, if you are a member of an HMO or CMP and develop end-stage renal disease, you cannot be disenrolled. (5) You will usually be required to receive all care from the HMO or CMP, except in emergency situations.

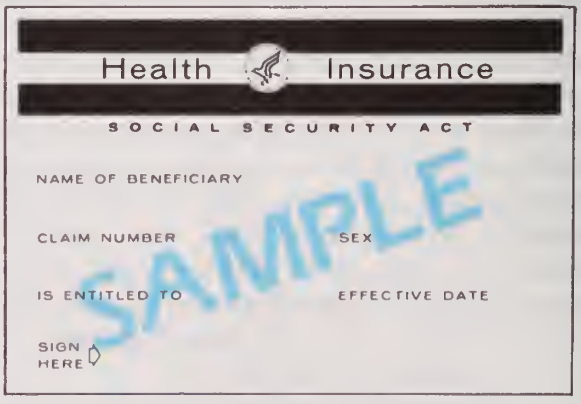


If you already belong to a Medicare HMO or CMP, there are some options you should know about. First, you may disenroll from the HMO/CMP at any time. Disenrollment can be handled by your plan or your local Social Security office. Second, if you feel that you have received poor quality care, you have several choices for action. (A) You have access to the prepayment plan's grievance procedures. (B) You may complain to your Peer Review Organization (PRO) or Quality Review Organization (QRO). (C) If you feel further appeal is appropriate, you can exercise your appeal rights—rights that are similar to those that you are guaranteed under traditional fee-for-service Medicare. (see page 21)

If you want to know whether there are prepayment plans with Medicare contracts in your area, contact a Social Security office. If you wish to obtain information about how to enroll in an HMO or CMP, what benefits are provided, and what the membership rules are, you should contact the HMO or CMP directly.

YOUR MEDICARE CARD

The Medicare card (see below) shows the Medicare coverage you have (hospital insurance, medical insurance, or both) and the date your protection started. If you don't have both parts of Medicare, see page 23 for information on how you may obtain the part you don't have.



Your card also shows your health insurance claim number. Sometimes this claim number is referred to as your Medicare number.

The claim number has nine digits and a letter. On some cards, there may also be another number after the letter. Your full claim number must always be included on all Medicare claims and correspondence. When a husband and wife both have Medicare, each will receive a separate card and claim number. Each spouse must use the exact name and claim number shown on his or her card.

It is important that you remember to:

(1) Always show your Medicare card when you receive services that Medicare can help pay for.

(2) Always write your health insurance claim number (including the letter) on any bills you send in and on any correspondence about Medicare. Also, you should have your Medicare card available when you make a telephone inquiry.

(3) Carry your card with you whenever you are away from home. If you ever lose it, immediately ask your Social Security office to get you a new one.

(4) Use your Medicare card only after the effective date shown on it.

(5) Never permit someone else to use your Medicare card.

BUYING HEALTH INSURANCE TO SUPPLEMENT MEDICARE

Medicare provides basic protection against the high cost of health care, but it will not pay all of your medical expenses, nor most long term care expenses. For this reason, many private insurance companies sell insurance to supplement Medicare. The Federal Government does not sell or service such insurance.

If, as of January 1, 1989 you own a policy to supplement Medicare, you will receive a notice from your insurer by January 31, 1989, explaining the changes in Medicare's coverage due to the Medicare Catastrophic Coverage Act. This notice will inform you of any changes to your supplemental coverage necessary because of the changes in Medicare and also tell you about any premium adjustments. As the new Medicare benefits are phased in, insurers are expected to change their benefit plans and premiums. You may wish to re-evaluate your insurance needs based on your health status and financial resources as these new benefits become effective.

If you are thinking about buying private insurance to supplement your Medicare protection, you should shop carefully. You can call any Social Security office and ask for the free pamphlet, ***Guide to Health Insurance for People with Medicare.*** This pamphlet explains how supplemental insurance works and how to shop for it. This pamphlet also lists the names, addresses and telephone numbers of your State Insurance Department and your State Agency on Aging. These offices can provide you valuable help on making your decision about whether to buy insurance to supplement Medicare.

There are Federal criminal and civil penalties (fines) for certain actions in selling health insurance to supplement Medicare. These penalties may be imposed against any insur-

ance company or agent who knowingly sells you a policy that duplicates Medicare coverage or any private health insurance that you already own, but which will not pay duplicate benefits. Penalties also apply if insurance agents misrepresent to you that they are employees or agents of the Medicare program or of any Government agency. There is also a penalty for making a false statement about a policy's meeting legal standards for certification when it does not, and for using the mails in a State for delivering advertisements of health insurance policies to supplement Medicare if the policies have not been approved for sale in that State.

If you suspect that you have been the victim of these or any other illegal sales practices, you should contact your State Insurance Department. The telephone numbers to call are listed in the back of the pamphlet ***Guide to Health Insurance for People with Medicare*** available at your Social Security Office. Also, you may call this Federal Medicare toll free number: 1-800-888-1998.

FRAUD AND ABUSE HOT LINE

If you have reason to believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services or is billing Medicare for services you did not receive, you may call a toll-free Hot Line. The Hot Line has been installed by the Department of Health and Human Services' Inspector General to receive any evidence of such fraud or abuse of the Medicare program.

The toll-free number is (800) 368-5779. In Maryland, call (800) 638-3986. **Please do not call the Inspector General's Hot Line for Medicare policy questions or questions about delayed claims or payments.**

HOSPITAL INSURANCE

This section tells you about:

THE PROSPECTIVE PAYMENT SYSTEM

Medicare pays for most inpatient hospital care under the Prospective Payment System (PPS). Under PPS, hospitals are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay. In some cases, the Medicare payment will be more than the hospital's costs; in other cases, the payment will be less than the hospital's costs. In special cases, where costs for necessary care are unusually high, or the length of stay is unusually long, the hospital receives additional payment.

It is important to remember that this system does not change your Medicare hospital insurance protection as described in this handbook. It does not determine the length of your stay in the hospital or the extent of care you receive. The law requires participating hospitals to accept Medicare payments as payment in full, and those hospitals are prohibited from billing the Medicare patient for anything other than the applicable deductible amounts, plus any amounts due for noncovered items or services, such as television, private duty nurses, or cosmetic surgery.

MEDICARE HOSPITAL INSURANCE

Medicare hospital insurance helps pay for four kinds of care: (1) inpatient hospital care; (2) medically necessary inpatient care in a skilled nursing facility; (3) home health care; and (4) hospice care.

Skilled nursing facility care is the only type of nursing home care that Medicare covers. **Medicare does not pay for care that is primarily custodial.** Medicare hospital insurance will pay for most but not all of the services you receive in a hospital or skilled nursing facility or from a home health agency

or hospice program. There are covered services and noncovered services under each kind of care. Covered services are services and supplies that hospital insurance can pay for.

You do not have to send Medicare any bills for care you receive from a participating hospital, skilled nursing facility, home health agency or hospice. Medicare will pay your benefits directly to the place where you received the care.

Whenever a hospital, skilled nursing facility, home health agency, or hospice sends Medicare a hospital insurance claim for payment, you will get a Medicare Benefit Notice that explains the decision made on the claim. If you have any questions about the notice, get in touch with the office shown on the notice.

WHEN YOU ARE A HOSPITAL INPATIENT

Medicare hospital insurance can help pay for inpatient hospital care if all of the following four conditions are met: (1) a doctor prescribes inpatient hospital care for treatment of your illness or injury, (2) you require the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review Committee of the hospital or a Peer Review Organization does not disapprove your stay.

If you meet these four conditions, Medicare will pay for unlimited* medically necessary inpatient hospital care after you pay a yearly deductible. The deductible for calendar year 1989 is $560. (A deductible is an amount you must pay before Medicare begins paying for services and supplies covered by the program.) You pay only one deductible each year, regardless of the costs, length of stay or number of times you are admitted to the hospital during the year. And if you paid a hospital deductible in December of 1988, you do not have to pay a deductible again in January if you are still a patient in or are readmitted to a hospital in January of the following year.

* Medicare pays for only limited inpatient psychiatric care (see page 10). The hospital can tell you about these limits.

Major services covered when you are a hospital inpatient

Medicare hospital insurance can pay for these services:

- A semiprivate room (2 to 4 beds in a room)
- All your meals, including special diets
- Regular nursing services
- Costs of special care units, such as intensive care unit, coronary care unit, etc.
- Drugs furnished by the hospital during your stay
- Blood transfusions furnished by the hospital during your stay (see below for information about coverage of blood)
- Lab tests included in your hospital bill
- X-rays and other radiology services, including radiation therapy, billed by the hospital
- Medical supplies such as casts, surgical dressings, and splints
- Use of appliances, such as a wheelchair
- Operating and recovery room costs, including hospital costs for anesthesia services
- Rehabilitation services, such as physical therapy, occupational therapy, and speech pathology services

Some services not covered when you are a hospital inpatient

Medicare hospital insurance cannot pay for these services:

- Personal convenience items that you request such as a telephone or television in your room
- Private duty nurses
- Any extra charges for a private room unless it is determined to be medically necessary

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 20.)

Coverage of Blood Under Hospital Insurance

Hospital insurance can help pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of

blood processing and administration. If you receive blood as an inpatient of a hospital or skilled nursing facility, hospital insurance can pay all of these blood costs, except for any nonreplacement fees charged for the first 3 pints of whole blood or units of packed red cells per calendar year. The nonreplacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

You are responsible for the nonreplacement fees for the first 3 pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can either replace the blood personally or arrange to have another person or a blood assurance plan replace it for you. A hospital or skilled nursing facility cannot charge you for any of the first 3 pints of blood you replace or arrange to replace. (See page 18 for explanation of coverage of blood under Medicare medical insurance.)

Care In A Psychiatric Hospital

Hospital insurance can help pay for no more than 190 days of care in a participating psychiatric hospital in your lifetime. Once you have used these 190 days, hospital insurance cannot pay for any more care in a psychiatric hospital.

Also, there is a special rule that applies if you are in a participating psychiatric hospital at the time your hospital insurance starts. Any Social Security office can give you information about this special rule.

Care in a Foreign Hospital

Medicare generally cannot pay for hospital or medical services outside the United States. (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States, along with the 50 States and the District of Columbia.) However, it can help pay for care in qualified Canadian or Mexican hospitals in three situations. These are: (1) you are in the U.S. when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest U.S. hospital that can provide the emergency services you need, (2) you live in the U.S. and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital that can provide the care you need, regardless of whether or not an emergency exists, and (3) you are in Canada traveling by the most direct route to or from Alaska and another State and an emergency occurs that requires that you be admitted to a Canadian hospital.

When hospital insurance covers your inpatient stay in a Canadian or Mexican hospital, your medical insurance can cover necessary doctors' services and any required use of an ambulance. If the hospital does not submit the claim to Medicare, any Social Security office will help you get Medicare payment for the covered services you receive. If you are planning to travel overseas, you may want to inquire about the availability of special short-term health insurance for foreign travel.

Care in a Christian Science Sanatorium

Medicare hospital insurance can help pay for inpatient hospital and skilled nursing facility services you receive in a participating Christian Science sanatorium if it is operated or listed and certified by the First Church of Christ, Scientist, in Boston.

SKILLED NURSING FACILITY CARE

Medicare hospital insurance can help pay for inpatient care in a Medicare-certified skilled nursing facility if your condition requires daily skilled nursing or rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility.

A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services. Most nursing homes in the United States are not skilled nursing facilities, and many skilled nursing facilities are not certified by Medicare. In some facilities, only certain portions are certified to participate in Medicare. If you are not sure whether

a facility or a particular portion is certified to participate in Medicare as a skilled nursing facility, ask someone at the facility or call a Social Security office.

Hospital insurance can help pay for care in a skilled nursing facility if both of the following conditions are met: (1) a doctor certifies that you need, and you actually receive, skilled nursing or skilled rehabilitation services on a daily basis, and (2) the Medicare intermediary or the facility's Utilization Review Committee does not disapprove your stay.

Both conditions must be met. But it's especially important to remember the requirement that you must need skilled nursing care or skilled rehabilitation services on a daily basis.

Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist. The skilled nursing care and skilled rehabilitation services you receive must be based on a doctor's orders.

Hospital insurance cannot pay for your stay if you need skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if you do not need to be in a skilled nursing facility to get skilled services. Also, hospital insurance cannot pay for your stay if you are in a skilled nursing facility mainly because you need custodial care (see page 22).

When your stay in a skilled nursing facility is covered by Medicare, hospital insurance can help pay for up to 150 days a calendar year, but only if you need daily skilled nursing care or rehabilitation services for that long.

If you are admitted to a skilled nursing facility in 1989, you will have to pay $25.50 in coinsurance each day for the first eight days of care during the year. (The coinsurance amount will increase in future years.) Medicare pays all other allowable charges for up to 150 days even if you are discharged and readmitted to a skilled nursing facility more than once during the year.

Hospital insurance does not cover your doctor's services while you are in a skilled nursing facility. Medicare medical insurance covers doctors' services. Page 13 tells you how medical insurance helps with doctor bills.

Major services covered when you are in a skilled nursing facility

Medicare hospital insurance can pay for these services:

- A semiprivate room (2 to 4 beds in a room)
- All your meals, including special diets
- Regular nursing services
- Rehabilitation services, such as physical, occupational, and speech therapy
- Drugs furnished by the facility during your stay
- Blood transfusions furnished to you during your stay (see page 9 for information about coverage of blood)
- Medical supplies such as splints and casts
- Use of appliances such as a wheelchair

Some services not covered when you are in a skilled nursing facility

Medicare hospital insurance cannot pay for these services:

- Personal convenience items that you request such as a television in your room
- Private duty nurses
- Any extra charges for a private room, unless it is determined to be medically necessary
- Custodial nursing home care services provided to persons with chronic, long-term illnesses or disabilities.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 20.)

HOME HEALTH CARE

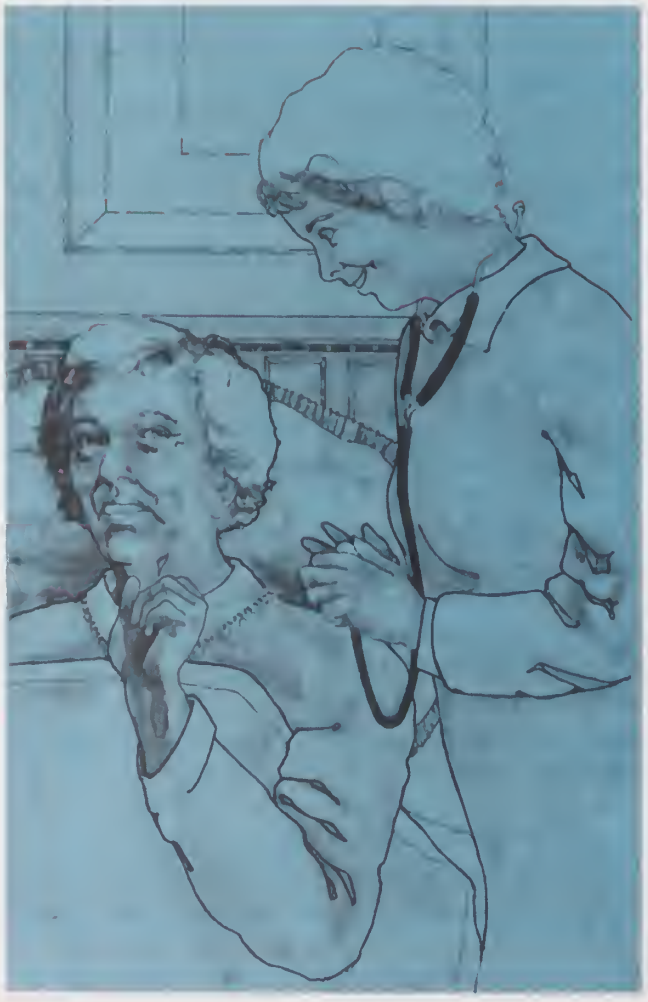
If you need part-time skilled health care in your home for the treatment of an illness or injury, Medicare can pay for covered home health visits furnished by a participating

home health agency. A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy in your home. (A facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

Medicare can pay for home health visits only if all of the following four conditions are met:

(1) the care you need includes intermittent skilled nursing care, physical therapy, or speech therapy,
(2) you are confined to your home,
(3) a doctor determines you need home health care and sets up a home health plan for you, and
(4) the home health agency providing services is participating in Medicare.

Once these conditions are met, either hospital insurance or medical insurance can pay for all medically necessary home health visits. When you no longer need intermittent skilled nursing care, physical therapy, or speech therapy, Medicare can continue to pay for home health visits if you need occupational therapy.



Medicare does not cover general household services, meal preparation, shopping, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs.

Home health services covered by Medicare

Medicare can pay for these services:

- Part-time or intermittent skilled nursing care
- Physical therapy
- Speech therapy

If you need intermittent skilled nursing care, physical therapy, or speech therapy, Medicare can also pay for:

- Occupational therapy
- Part-time or intermittent services of home health aides
- Medical social services
- Medical supplies
- Durable medical equipment (80% of approved cost)

Home health services not covered by Medicare

Medicare cannot pay for these services:

- Full-time nursing care at home
- Drugs and biologicals
- Meals delivered to your home
- Homemaker services
- Blood transfusions

Medicare pays the full approved cost of all covered home health visits. You may be charged only for any services or costs that Medicare does not cover.

The home health agency will submit the claim for payment. You don't have to send in any bills yourself.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 20.)

HOSPICE CARE

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Medicare hospital insurance can help pay for hospice care if all of the following three conditions are met:

(1) a doctor certifies that a patient is terminally ill,
(2) a patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness, and
(3) care is provided by a Medicare-certified hospice program.

Special benefit periods apply to hospice care. Hospital insurance can pay for two 90-day periods, one subsequent 30-day period, and a further extension period of indefinite length. A beneficiary may disenroll from the hospice during either 90-day period and return to regular Medicare coverage, then later re-elect the hospice benefit.

There are no deductibles under the hospice benefit. Medicare pays the full cost of all covered services for the terminal illness, except for small coinsurance amounts for outpatient drugs and inpatient respite care. The patient is responsible for 5 percent of the cost of outpatient drugs or $5 toward each prescription, whichever is less. For inpatient respite care, the patient pays 5 percent of the Medicare-allowed rate (approximately $3.25 per day in 1989). The rate varies slightly depending on the geographic area of the country.

Respite care is a short-term inpatient stay, which may be necessary for the patient, to give temporary relief to the person who regularly assists with home care. Each inpatient respite care stay is limited to no more than five days in a row.

While receiving hospice care, if a patient requires treatment for a condition not related to the terminal illness, Medicare continues to help pay for all necessary covered services under the standard Medicare benefit program.

Services covered when provided by a hospice

Medicare hospital insurance can pay for these services for beneficiaries as part of hospice care:

- Nursing services
- Doctors' services
- Drugs, including outpatient drugs for pain relief and symptom management
- Physical therapy, occupational therapy and speech-language pathology
- Home health aide and homemaker services
- Medical social services
- Medical supplies and appliances
- Short-term inpatient care, including respite care
- Counseling

The Medicare hospital insurance hospice benefit **cannot** pay for treatments other than for pain relief and symptom management of a terminal illness.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision. (See page 20)

MEDICAL INSURANCE

This section tells you about:

Medicare medical insurance can help pay for (1) doctor's services, (2) outpatient hospital care, (3) diagnostic tests, (4) durable medical equipment, (5) ambulance service, and (6) many other health services and supplies which are not covered by Medical hospital insurance.

The following sections will tell you more about these different kinds of care, the services that are and are not covered by medical insurance, and what part of your medical expenses Medicare can pay.

DEDUCTIBLE AND COINSURANCE AMOUNTS

After you have paid $75 in approved charges (see below) for covered medical expenses in 1989, medical insurance generally will pay 80 percent of the approved charges for any additional covered services you receive during the rest of the year. You are responsible for the remaining 20 percent. Medicare will determine the "approved" or "reasonable" charge for each service you receive.

The first $75 in covered expenses is called the medical insurance deductible. You need to meet this $75 deductible only once during the year. The deductible can be met by any combination of covered expenses. You do not have to meet a separate deductible for each different kind of covered service you might receive.

The deductible applies to your expenses related to doctors, providers and suppliers. Suppliers are persons or organizations other than doctors or health care facilities that furnish equipment or services covered by medical insurance.

COVERED DOCTORS' SERVICES

Medicare medical insurance can help pay for covered services you receive from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location in the U.S. Your medical insurance can also help pay for doctors' services you receive in connection with covered inpatient care in a Canadian or Mexican hospital. See page 10 to find out about care in Canadian and Mexican hospitals.

Major doctors' services covered by medical insurance

Medicare medical insurance can help pay for these services:

- Medical and surgical services, including anesthesia
- Diagnostic tests and procedures that are part of your treatment
- Radiology and pathology services by doctors while you are a hospital inpatient or outpatient.
- Other services which are ordinarily furnished in the doctor's office and included in his or her bill, such as:
  - — X-rays
  - — Services of your doctor's office nurse
  - — Drugs and biologicals that cannot be self-administered
  - — Transfusions of blood and blood components
  - — Medical supplies
  - — Physical/occupational therapy and speech pathology services

Some doctors' services not covered by medical insurance

Medicare medical insurance cannot pay for these services:

- Most routine physical examinations and tests directly related to such examinations
- Routine foot care
- Eye or hearing examinations for prescribing or fitting eyeglasses or hearing aids
- Immunizations (except pneumococcal vaccinations or immunizations required because of an injury or immediate risk of infection, and hepatitis B for certain persons at risk)
- Cosmetic surgery unless it is needed because of accidental injury or to improve the function of a malformed part of the body

Chiropractors' services

Medical insurance helps pay for only one kind of treatment furnished by a licensed, Medicare-certified chiropractor. The only treatment that can be covered is manual

manipulation of the spine to correct a subluxation that can be demonstrated by X-ray. Medical insurance does not pay for any other diagnostic or therapeutic services, including X-rays, furnished by a chiropractor.

Podiatrists' services

Medical insurance can help pay for any covered services of a licensed podiatrist, including the removal of plantar warts. Treatment of mycotic toenails (a fungus infection) is limited to once every 60 days unless the medical necessity for more frequent treatment is documented by your physician or podiatrist.

Medical insurance generally does not cover routine foot care such as hygienic care; treatment for flat feet or other structural misalignments of the feet; and removal of corns, calluses, and most warts. But, medical insurance can help pay for routine foot care if you have a medical condition affecting the lower limbs (such as severe diabetes) which requires that such care can be performed by a podiatrist or a doctor of medicine or osteopathy.

Dental care

Medical insurance can help pay for dental care only if it involves (1) surgery of the jaw or related structures, (2) setting fractures of the jaw or facial bones, or (3) services that would be covered when provided by a doctor. If you need to be hospitalized because of the severity of a dental procedure, Medicare can cover your hospital stay even if the dental care itself is not covered by Medicare.

Care in connection with the treatment, filling, removal, or replacement of teeth; root canal therapy; surgery for impacted teeth; and other surgical procedures involving the teeth or structures directly supporting the teeth generally are not covered.

Optometrists' services

Medicare can help pay for the vision care services of optometrists, if the services are among those already covered by Medicare and if the optometrist is legally authorized to perform such services in your State. However, Medicare will not pay for routine eye exams, and it will not pay for eyeglasses or corrective lenses unless they are prosthetic lenses that replace the natural lens of the eye.

SECOND OPINION BEFORE SURGERY

Sometimes your doctor will recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, we recommend that you get a second doctor's opinion to help you decide about surgery. Medical insurance will help pay for a second opinion in the same way it pays for other services by doctors.

Your own doctor is the best source for referral to another doctor. But, if you wish, you can call Medicare's Second Opinion Referral Center for the names and phone numbers of doctors in your area who provide second opinions. The toll-free number is 1-800-638-6833 (in Maryland 1-800-492-6603).

OTHER MEDICAL SERVICES

Outpatient Hospital Services

Medicare medical insurance helps pay for covered services you receive as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury. Under certain conditions, medical insurance can also help pay for emergency outpatient care you receive from a non-participating hospital.

When you go to a hospital for outpatient services, be sure to show the people there your most recent *Explanation of Medicare Benefits* notice. From this form, they usually can tell how much of the $75 deductible you have met.

If the hospital cannot tell how much of the $75 deductible you have met and the charge for the services you received is less than $75, the hospital may ask you to pay the entire bill. The amount you pay the hospital can be credited toward any part of the deductible

you have not met, and any medical insurance payments due will be paid directly to you.

Major outpatient hospital services covered by medical insurance

Medicare medical insurance helps pay for these services:

- Services in an emergency room or outpatient clinic
- Laboratory tests billed by the hospital
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Drugs and biologicals which cannot be self-administered
- Blood transfusions furnished to you as an outpatient

Some outpatient hospital services not covered by medical insurance

Medicare medical insurance cannot pay for these services:

- Routine physical examinations and tests directly related to such examinations
- Eye or ear examinations to prescribe or fit eyeglasses or hearing aids
- Immunizations (except pneumococcal and Hepatitis B vaccinations, or immunizations required because of an injury or immediate risk of infection)
- Routine foot care

Hospital outpatient mental health services

Medicare can help pay for mental health care in a hospital outpatient program for treatment of mental illness, so long as a doctor certifies that your treatment is necessary and that without treatment you would require hospitalization.

After you have met the $75 yearly deductible, Medicare will pay 80 percent of the cost of this hospital outpatient care. This benefit is not subject to the hospital insurance lifetime limit of 190 days of inpatient hospitalization for treatment of mental illness. Nor is it subject (except in the case of physician services) to the medical insurance payment limit of $1,100 per year for outpatient treatment of mental illness.

Ambulatory surgical services

Some surgery can be performed safely on an outpatient basis, avoiding the need for an inpatient hospital stay. Medicare can pay 80 percent of the center's approved fee for certain specified outpatient surgical procedures performed in a Medicare-certified ambulatory surgical center. The center can be affiliated with a hospital or it can be independent, but it must provide only ambulatory surgery services and must have an agreement with Medicare to do so.

After you have met the $75 deductible, Medicare will pay 80 percent of your surgeon's and anesthesiologist's approved charge for services. Such services can include pre- and post-operative care furnished on an outpatient basis in an ambulatory surgical center in a hospital.

Outpatient physical and occupational therapy and speech pathology services

Medicare medical insurance can help pay for medically necessary outpatient physical and occupational therapy or speech pathology services, if all the following three conditions are met:

(1) your doctor must prescribe the service,
(2) your doctor or therapist must set up a plan of treatment, and
(3) your doctor must periodically review that plan.

You may receive physical therapy, occupational therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a home health agency, clinic, rehabilitation agency, or public health agency approved by Medicare. The organization providing services always submits the claim and may only charge you for any part of the $75 deductible you had not met, 20 percent of the remaining approved amount, and any noncovered services.

You may receive services directly from an independently practicing, Medicare-certified physical or occupational therapist in his or her office or in your home if such treatment is prescribed by a doctor. But, the maximum amount medical insurance can pay for these

services is $400 a year. The medical insurance payment would be less than $400 if charges for these services are used to meet part or all of your $75 deductible. Either you or the therapist can submit the claim as described on page 24.

Comprehensive outpatient rehabilitation facility services

Under certain circumstances, Medicare can help pay for outpatient services you receive from a comprehensive outpatient rehabilitation facility (CORF). Covered services include physicians' services; physical, speech, occupational and respiratory therapies; counseling; and other related services. You must be referred by a physician who certifies that you need skilled rehabilitation services. For most CORF services, you are responsible only for the annual deductible and 20 percent of the Medicare approved charges. For mental health treatment in a CORF, the maximum Medicare can pay is $1,100 a year for physicians' services and CORF services combined.

Independent clinical laboratory services

Medical insurance can pay the full approved fee for covered clinical diagnostic tests provided by independent laboratories that are certified to perform them. The laboratory must accept assignment for these tests. It may not bill you for the tests. If a doctor prescribes tests which the laboratory is not certified to perform, Medicare cannot pay for the tests, and you can be required to pay for them. Not all laboratories are certified by Medicare and some laboratories are certified only for certain kinds of tests. Your doctor can usually tell you which laboratories are certified and whether the tests he or she is prescribing from a certified laboratory are covered by medical insurance. Your doctor must accept assignment for covered clinical diagnostic laboratory tests which he or she furnishes. He or she may not bill you for them.

Portable diagnostic X-ray services

Medical insurance helps pay the approved charges for portable diagnostic X-ray services you receive in your home if they are ordered by a doctor and if they are provided by a Medicare-certified supplier.

Ambulance transportation

Medical insurance can help pay for medically necessary ambulance transportation but only if (1) the ambulance, equipment and personnel meet Medicare requirements, and (2) transportation in any other vehicle could endanger the patient's health.

Under these conditions, medical insurance can help pay for ambulance transportation to a hospital or skilled nursing facility, or from a hospital or skilled nursing facility to your home. Also, if you are an inpatient in a hospital or skilled nursing facility which cannot provide a medically necessary service you need, medical insurance can help pay for round trip ambulance transportation to the nearest appropriate facility.

Medical insurance cannot pay for ambulance use from your home to a doctor's office.

Medical insurance usually can help pay for ambulance transportation only in your local area. But, if there are no local facilities equipped to provide the care you need, medical insurance will help pay for necessary ambulance transportation to the closest facility outside your local area that can provide the necessary care. If you choose to go to another institution that is farther away, Medicare payment still will be based on the reasonable charge for transportation to the closest facility.

Necessary ambulance services in connection with a covered inpatient stay in a Canadian or Mexican hospital (see page 10) can also be covered by medical insurance.

Durable medical equipment

Medical insurance can help pay for durable medical equipment such as oxygen equipment, wheelchairs, and other medically necessary

equipment that your doctor prescribes for use in your home. (A facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

Beginning on January 1, 1989, new rules will govern whether durable medical equipment must be rented or purchased. In general, durable medical equipment that costs more than $150 must be rented. Inexpensive durable medical equipment can be either purchased or rented. Your carrier will be able to provide more specific guidance on these rules.

Blood

Medical insurance can help pay for blood and blood components you receive as an outpatient or as part of other covered services, except for any nonreplacement fees charged for the first 3 pints or units received in each calendar year. After you have met the $75 deductible, medical insurance pays 80 percent of the approved charges for blood, starting with the fourth pint in a calendar year.

Prosthetic devices

Medical insurance helps pay for prosthetic devices needed to substitute for an internal body organ. These include Medicare-approved corrective lenses needed after a cataract operation, colostomy or ileostomy bags and certain related supplies, and breast prostheses (including a surgical brassiere) after a mastectomy. Medical insurance can also help pay for artificial limbs and eyes, and for arm, leg, back, and neck braces. Orthopedic shoes are covered **only** when they are part of leg braces and the cost is included in the orthopedist's charge. Dental plates or other dental devices are not covered.

Pneumococcal vaccine

Medical insurance will pay the full approved charges for pneumococcal vaccine and its administration. Neither the $75 annual deductible nor the 20 percent coinsurance apply to this service.

Hepatitis B vaccine

Medicare will help pay for hepatitis B vaccine administered to beneficiaries considered to be at high or intermediate risk of contracting the disease.

Medical supplies

Medical insurance can also help pay for surgical dressings, splints, casts, and similar medical supplies ordered by a doctor in connection with your medical treatment. This does not include adhesive tape, antiseptics, or other common first-aid supplies.

Other covered services and supplies

Medical insurance helps pay for rural health clinic services; dialysis services; physician assistant, certified registered nurse anesthetist, nurse-midwife, and psychologist services; and for antigens and blood clotting factors. Some providers of these services are required to take assignment. The person or group who furnishes your service should be able to tell you whether you can file the Medicare claim or whether they must file the claim for you.

Outpatient treatment of mental illness

Doctors' services and comprehensive outpatient rehabilitation facility services you receive for outpatient treatment of a mental illness are covered under a special payment rule, but the maximum amount medical insurance can pay in 1989 for these services is $1,100. The medical insurance payment would be less than $1,100 if charges for these services are used to meet part or all of your $75 deductible. (Medicare coverage of **hospital outpatient** treatment of mental illness is described on page 16; Medicare coverage of treatment of mental illness in a comprehensive outpatient rehabilitation facility is described on page 17.)

PARTICIPATING DOCTORS AND SUPPLIERS

Doctors and suppliers can sign agreements to become Medicare-participating doctors or suppliers. This means that they have agreed in advance to accept assignment on all Medicare claims. Doctors and suppliers are given the opportunity to sign participation agreements each year. Medicare-participating doctors and suppliers can display emblems or certificates which show that they accept assignment on all Medicare claims.

The names and addresses of Medicare-participating doctors and suppliers are listed by geographic area in the "Medicare-Participating Physician/Supplier Directory." You can get the directory for your area free of charge from your Medicare carrier (see page 33); or you can call your carrier and ask for names of some participating doctors in your area. Also, this directory is available for review in all Social Security offices, State and area offices of the Administration on Aging, and in most hospitals.

ASSIGNMENT

The assignment method, in which the doctor or supplier receives the medical insurance payment directly from Medicare, can save you time and money. When the assignment method is used, the doctor or supplier agrees to accept the charge approved by the Medicare carrier for the covered services. Medicare pays your doctor or supplier 80 percent of the approved charge, after subtracting any part of the $75 deductible you have not met. The doctor or supplier can charge you only for the part of the $75 deductible you have not met and for the coinsurance, which is the remaining 20 percent of the approved charge. Of course, your doctor or supplier also can charge you for any services that Medicare does not cover.

If your doctor does not accept assignment, Medicare pays you 80 percent of the approved charge, after subtracting any part of the $75 deductible you haven't met. The doctor can bill you his or her actual charge. Below are examples of the two payment methods (in both examples, the $75 deductible has already been met).

	Actual Charge	Medicare Approved Charge	Medicare Pays	You Are Responsible for
Doctor Accepts Assignment	$500	$400	$320 (80% of approved charge)	$80 (20% of approved charge)
*Doctor Does Not Accept Assignment	$500	$400	$320 (80% of approved charge)	$180 (difference between actual charge and Medicare payment)

* Medicare law requires doctors who do not take assignment for elective surgery to give you a written estimate of your out-of-pocket costs if the total charge is $500 or more.

PARTICIPATING PROVIDERS

Hospitals, skilled nursing facilities, home health agencies, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical and occupational therapy and speech pathology services, are all participating providers under Medicare medical insurance. They submit their claims directly to Medicare—you cannot submit claims for their services. The medical insurance payment made to the provider relieves you of responsibility for 80 percent of the provider's charges for the covered services you receive, after subtracting any part of the $75 deductible you have not met. The provider will charge you for the part of the deductible you have not met, plus 20 percent of the billed charges.

EXPLANATION OF MEDICARE BENEFITS NOTICE

After you or the doctor or supplier sends in a medical insurance claim, Medicare will send you a notice called *Explanation of Medicare Benefits* to tell you the decision on the claim.

This notice shows what services were covered, what charges were approved, how much was credited toward your $75 yearly deductible, and the amount Medicare paid. Please examine the notice carefully. If you believe payment was made for a service or supply you didn't receive, or the payment is otherwise questionable, you may call the carrier that handled your claim. If you wish to call the carrier, a toll-free number is contained on the notice and on pages 33 through 37 of this handbook. You must contact the carrier yourself.

APPROVED OR "REASONABLE CHARGES"

Medicare medical insurance payments are based for the most part on what the law defines as "reasonable charges" or the amounts approved by the Medicare carrier. Because of the way the approved amounts are determined and because of high rates of inflation in medical care prices, the charges approved are often less than the actual charges billed by doctors and suppliers. Medical insurance usually pays only 80 percent of the approved charge even if it is less than the actual charge.

When a medical insurance claim which is reimbursable on a reasonable charge basis is submitted, the carrier compares the actual charge shown on the claim with the customary and prevailing charges for that service. The charge approved by the carrier will be either: the customary charge (the charge most frequently made by the doctor or supplier for each item or service); the prevailing charge (based on all the customary charges in the locality for each type of service); or the actual charge, whichever is the lowest.

YOUR RIGHT OF APPEAL

This section tells you about:

If you disagree with a decision on the amount Medicare will pay on a claim or whether services you received are covered by Medicare, you have the right to appeal the decision.

In many instances the first written denial notice you receive will come from the provider of the services (e.g., a hospital, skilled nursing facility, home health agency, or a hospice). The notice from the provider should explain why it believes Medicare will not pay for the services. You do not have the right to appeal the provider's notice as it is not considered a Medicare decision. If you disagree, ask the provider to file a claim on your behalf to Medicare, (which the provider must do), so you can receive a Medicare decision regarding your claim. You then have the right to appeal the Medicare decision if you still disagree.

The notice you receive from Medicare which tells you of the decision made on a claim will also tell you exactly what appeal steps you can take. If you ever need more information about your right to appeal and how to request it, call any Social Security office, the Medicare intermediary or carrier, or the Peer Review Organization in your State. The following is a brief summary of the different Medicare appeals processes.

APPEALING DECISIONS BY PEER REVIEW ORGANIZATIONS (PROs)

Peer Review Organizations make decisions on the need for hospital care (see page 4 for a description of PROs). Whenever you are admitted to a Medicare participating hospital, you will be given *An Important Message From Medicare*. This briefly describes your rights to a review by the PRO, should the hospital give you a notice of non-coverage. The message includes the name, address, and phone number of the PRO in your State.

Once the PRO makes a determination about your case, you can appeal by requesting a reconsideration—if you disagree with the decision of the PRO. Then, if you disagree with the PRO's reconsideration decision and the amount in question is $200 or more, you can request a hearing by an Administrative Law Judge. Cases involving $2,000 or more can eventually be appealed to a Federal Court.

APPEALING ALL OTHER HOSPITAL INSURANCE DECISIONS

Unless you are a member of an HMO or CMP, appeals of decisions on all other services covered under Medicare hospital insurance (skilled nursing facility care, home health care, hospice services, and some inpatient hospital matters not handled by PROs) are handled by Medicare intermediaries. If you disagree with the intermediary's initial decision, you may request a reconsideration. The request can be submitted directly to the intermediary or through your Social Security office. If you disagree with the intermediary's reconsideration decision and the amount in question is $100 or more, you can request a hearing by an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court, after review by the Appeals Council.

APPEALING DECISIONS BY HEALTH MAINTENANCE ORGANIZATIONS (HMOs) AND COMPETITIVE MEDICAL PLANS (CMPs)

If you are a member of a Medicare-certified Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP), decisions about coverage and payment for services will usually be made by your HMO/CMP. Your appeal rights are similar to the rights of Medicare beneficiaries under traditional fee-for-service Medicare. Also, Federal law requires Medicare-certified HMOs and CMPs to provide a full, written explanation of appeal rights to all members at the time of enrollment, and at least once a year thereafter. If you are a member of such a plan and you have not received a written explanation of your appeal rights, you should request one from your plan's membership office or write to the Health Care Financing Administration.

APPEALING DECISIONS ON MEDICAL INSURANCE CLAIMS

Under Medicare medical insurance, either you, your doctor, your provider, or your supplier submits the claim for payment. Medicare will send you an explanation of the claim decision on a form called *An Explanation of Medicare Benefits* (EOMB). The form also explains how you can appeal denials or payment decisions with which you disagree, and gives the name, address, and State-wide toll-free number of the carrier (the names and addresses of the carriers and the areas they serve are also listed at the back of this handbook on pages 33 to 37). If you disagree with the decision on your claim, you can ask the carrier to review it. Then, if you disagree with the carrier's written explanation of its review decision and the amount in question is $100 or more, you can request a hearing by the carrier. (To reach the $100 amount, you can count other claims that have been reviewed within the past six months.)

If you disagree with the carrier hearing decision and the amount in question is $500 or more, you can request a hearing before an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court, after review by the Appeals Council.

WHAT MEDICARE DOES NOT COVER

* Care That is Custodial (see this page)
* Care That is Not Reasonable and Necessary under Medicare Program Standards . . .(see this page)
* Services Not Covered .(see this page)
* Limit of Beneficiary Liability . . . . . .(see page 23)

CARE THAT IS CUSTODIAL

Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. Much of the care provided in nursing homes or by home agencies to persons with chronic, long-term illnesses or disabilities falls into this category. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if you are in a participating hospital or skilled nursing facility or you are receiving care from a participating home health agency, Medicare does not cover your care if it is mainly custodial.

CARE THAT IS NOT REASONABLE AND NECESSARY UNDER MEDICARE PROGRAM STANDARDS

If a doctor places you in a hospital or skilled nursing facility when the kind of care you need could be provided elsewhere, your stay would not be considered reasonable and necessary. So Medicare would not cover your stay. If you stay in a hospital or skilled nursing facility longer than you need to be there, Medicare payments would end when further inpatient care is no longer reasonable and necessary.

If a doctor (or other practitioner) comes to treat you or you visit him or her for treatment more often than is medically necessary, Medicare would not cover the "extra" visits. Medicare cannot cover more services than are reasonable and necessary for your treatment. Any decision of this kind is always based on professional medical advice.

SERVICES NOT COVERED

This alphabetical list shows most of the major services and supplies not usually paid for by Medicare. However, some of these items can be covered by Medicare under certain conditions described on the pages indicated.

Acupuncture
Chiropractic Services (see page 14)
Christian Science practitioners' services
Cosmetic surgery (see page 14)
Custodial care
Dental care (see page 15)
Drugs and medicines you buy yourself with or without a doctor's prescription (see page 13)
Eyeglasses and eye examinations for prescribing, fitting, or changing eyeglasses (see page 15)
Foot care that is routine (see page 15)
Hearing aids and hearing examinations for prescribing, fitting, or changing hearing aids
Homemaker services (see page 12)
Immunizations (see page 18)
Injections which can be self-administered, such as insulin
Long term care (nursing homes)
Meals delivered to your home
Naturopaths' services
Nursing care on full-time basis in your home
Orthopedic shoes unless they are part of a leg brace and are included in the orthopedist's charge
Personal convenience items that you request such as a phone or television in your room at a hospital or skilled nursing facility
Physical examinations that are routine (for example, yearly physical examinations) and tests directly related to such examinations
Private duty nurses
Private room (see page 9)
Services performed by immediate relatives or members of your household
Services provided outside the United States (see page 10)
Services which are not reasonable and necessary under Medicare program standards

Services payable by another government program.

LIMITATION OF LIABILITY

Under Medicare law you will not be held responsible for paying for certain health care services if you could not reasonably be expected to know that the services were not covered by Medicare. This is called limitation of liability, and is often referred to as a "waiver of liability." The waiver applies only when the care is not covered because it was custodial care or was not "reasonable or necessary" under Medicare program standards for diagnosis or treatment. The waiver also applies to denials of home health services where the patient is not homebound, or is not receiving skilled nursing care on an intermittent basis.

GETTING THE PART OF MEDICARE YOU DO NOT HAVE

This section tells you about:

MEDICAL INSURANCE

If you have Medicare hospital insurance but do not have the medical insurance part of Medicare, you can sign up for medical insurance during a general enrollment period. A general enrollment period is held January 1 through March 31 each year. Your protection will begin July 1 of the year you enroll. If you enroll during a general enrollment period, your monthly premium will be 10 percent higher than the basic premium for each 12-month period you could have had medical insurance but were not enrolled. (The basic medical insurance premium is $27.90 a month through December 31, 1989. This amount will change January 1, 1990.)

HOSPITAL INSURANCE

Some individuals 65 or older have Medicare medical insurance, but do not meet the requirements for premium-free hospital insurance. If you are in this category, you can get hospital insurance by paying a monthly premium. (This premium applies only to persons who are not entitled to hospital insurance through the Social Security or Railroad Retirement systems or government employment. The basic hospital insurance premium for 1989 is $156 a month through December 31, 1989. This amount will change January 1, 1990.)

You can sign up for premium hospital insurance during a general enrollment period: January 1 through March 31 each year. If you enroll during a general enrollment period that begins more than one year after your 65th birthday, your monthly premium will be 10 percent higher than the basic premium amount. Your protection will not begin until July 1 of the year you enroll.

For more information about premium amounts, premium surcharges, and how to get the part of Medicare you do not have, contact your Social Security office.

EVENTS THAT CAN CHANGE YOUR MEDICARE PROTECTION

This section tells you about:

WHEN PROTECTION ENDS FOR PERSONS 65 AND OLDER

If you have Medicare hospital insurance based on your husband's or wife's work record, your protection will end if you and your spouse divorce before your marriage has lasted 10 years. If you have hospital insurance based on your own work record, your protection will continue as long as you live.

Your medical insurance protection will stop if your premiums are not paid or if you voluntarily cancel. If you are thinking about cancelling your medical insurance, remember that you may not be able to get private insurance that offers the same protection. Also, if you cancel your medical insurance and then later decide to re-enroll, your premium may be higher and your protection will not begin again until July 1 of the year you re-enroll (unless you qualify for a special enrollment period as described on page 25).

If you are buying Medicare hospital insurance as described previously, you will lose it if you cancel your medical insurance. People who buy hospital insurance must enroll and pay the premium for medical insurance. But, you can cancel hospital insurance and still continue your medical insurance.

If you want more information about cancelling your Medicare protection, get in touch with any Social Security office.

WHEN PROTECTION ENDS FOR THE DISABLED

If you have Medicare because you are disabled, your protection will end if you recover from your disability before you are 65. If you go to work but are still disabled, your Medicare protection may continue for up to 48 months after you begin working.

WHEN PROTECTION ENDS FOR THOSE WITH PERMANENT KIDNEY FAILURE

If you have Medicare because of permanent kidney failure, your protection will end 12 months after the month maintenance dialysis treatment stops or 36 months after the month you have a successful kidney transplant.

Your medical insurance protection could stop before that for failure to pay premiums or if you decide to cancel. Call any Social Security office if you ever want to cancel your medical insurance protection.

If you need more information about Medicare coverage of permanent kidney failure, you can get a copy of ***Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*** from your Social Security office.

HOW TO SUBMIT MEDICAL INSURANCE CLAIMS

This section will tell you about:

SUBMITTING YOUR MEDICAL INSURANCE CLAIM

A Patient's Request for Medicare Payment form, also called Form 1490S (see page 29 for a sample form 1490S), must be submitted to the Medicare carrier for medical insurance to pay for covered services of doctors and suppliers. All Social Security offices and Medicare carriers, and most doctors' offices, have copies of the form. Instructions on how to fill it out are on the back of the form.

If the doctor or supplier is Medicare-participating, uses the assignment method of payment, or chooses to submit an unassigned claim for you, he or she submits the claim, and you do not have to use the 1490S form.

If the doctor or supplier does not accept assignment and does not submit the claim for you, you submit the claim, using the 1490S form. Complete and sign the form and attach itemized bills for the services you received.

An itemized bill must show (1) the date you received the services, (2) the place where you received the services, (3) a description of the services, (4) the charge for each service, (5) the doctor or supplier who provided the services, and (6) your name and your health insurance claim number, including the letter at the end of the number. If the bill doesn't include all of this information, your payment will be delayed. It is also helpful if the nature of your illness (diagnosis) is shown on the bill. If you are submitting a claim for the rental or purchase of durable medical equipment, you must include the bill from the supplier and the doctor's prescription. The prescription must show the equipment you need, the medical reason for the need, and an estimate of how long the equipment will be medically necessary.

You may submit several itemized bills with a 1490S form. It doesn't matter whether all

the bills are from one doctor or supplier or from different people who gave you services. You can send in the bills either before or after you pay them.

Before any medical insurance payment can be made, your record must show that you have met the deductible. So, as soon as your bills come to $75 in 1989, send them to your Medicare carrier with a 1490S form. Page 27 will tell you where to send your claim. Once you have met the $75 deductible, we suggest that you send in your future bills for covered services as soon as you get them so that Medicare payment can be made promptly.

If all your medical bills for the year amount to less than $75, medical insurance cannot pay any part of your bills for the year.

It's a good idea to keep a record of your medical insurance claim in case you ever want to inquire about it. Before you send in a claim, write down the date you mail it, the services you received, the date and charge for each service, and the name of the person who provided each service.

If you need to get information from your Medicare carrier about your claim record or find out more about a particular claim, you must write or call the carrier personally.

There are special rules for submitting your medical insurance claim if you are a member of an HMO or CMP. If you are a member of an HMO or CMP and you receive a bill for medical services, equipment or supplies, you may have to send the bill to your HMO or CMP for processing. You can find out who should process the claim by consulting your HMO/CMP membership handbook, or contacting your HMO/CMP.

WHEN OTHER INSURANCE PAYS FIRST

If any of the following insurance situations applies to you, please notify your doctor, hospital, or other provider of services and, except in the case of liability claims, file your claim with the other insurer first. You may want to file liability claims with Medicare first.

When you or your spouse continue to work

Medicare has special rules that apply to beneficiaries who have employer group health plan coverage through their employment or the employment of a spouse.

Employers with 20 or more employees are required to offer workers and their spouses age 65 and over the same health insurance benefits offered to younger workers and spouses. In such situations you and your spouse have the option to accept or reject your employer's health plan. If you accept it, Medicare will become the secondary payer. If you reject your employer's health plan, Medicare will remain the primary health insurance payer. If you elect Medicare to be the primary payer, your employer cannot offer you coverage that supplements Medicare.

For more information, contact your employer or ask any Social Security office for a free copy of *Medicare and Employer Health Plans.*

If you are disabled and under age 65

If certain disabled beneficiaries have coverage under an employer's health plan or the health plan of an employed family member, Medicare is the secondary payer. This provision applies to group health plans of businesses that employ 100 or more people. Employees of smaller firms and their dependents may also be covered under certain conditions.

Delayed enrollment under Medicare medical insurance

When you are covered by an employer health plan, you may be able to delay enrollment in Medicare's medical insurance without premium penalty. Your Social Security office can give you more information on special enrollment periods or delayed enrollment in Medicare's medical insurance.

Other situations where Medicare is the secondary payer

If you have a work related illness or injury, services provided as treatment of that illness

or injury should be covered by workers' compensation or Federal black lung benefits. It is important that your Medicare claim form note that the treatment is related to a work related illness or injury even if the injury or illness occurred in the past.

Medicare is a secondary payer for up to one year for beneficiaries who are eligible for Medicare solely on the basis of End Stage Renal Disease, if they have employer group health plan coverage.

Medicare also serves as the secondary payer in cases where automobile medical or no fault insurance or any liability insurance is available as the primary payer.

Although Medicare benefits are secondary to benefits paid by liability insurers, you must file claims with Medicare first, and Medicare will make a conditional payment. When a liability settlement is reached, Medicare will recover its conditional payments from the settlement amount.

If you are entitled to both Medicare and veterans benefits

An individual who is entitled to veterans benefits and to Medicare benefits may choose to receive treatment under either program. Under the law, Medicare cannot pay for services furnished by VA hospitals and VA medical facilities, except for certain emergency hospital services. Also, Medicare cannot pay if the VA has authorized payment for services that a veteran receives in a non-VA hospital or from a non-VA physician. Medicare can pay for covered services a veteran receives from non-VA hospitals and physicians if the VA has not authorized payment for the services.

Since July 1986, the VA has been charging copayments to some veterans with non-service connected conditions for treatment in a VA hospital or medical facility, or for VA authorized treatment by non-VA sources. The VA charges copayments when the veteran's income exceeds a particular level. If the VA charges the veteran a copayment for **VA authorized care by a non-VA physician or hospital,** Medicare may be able to reimburse the veteran, in whole or in part, for his or her VA copayment obligation. But Medicare may not reimburse a veteran for VA copayments for services furnished by VA hospitals and facilities, unless the services are emergency inpatient or outpatient **hospital** services. In the latter case, the Medicare payment is subject to Medicare deductible and coinsurance amounts.

For further information, contact your Medicare intermediary or carrier.

SUBMITTING CLAIMS FOR A PERSON WHO DIES

When a Medicare beneficiary dies, any hospital insurance payments due will be paid directly to the hospital, skilled nursing facility, home health agency or hospice that provided covered services.

For services covered under medical insurance, some special rules apply, depending on whether the doctor's or supplier's bill has been paid.

If the bill was paid by the patient or with funds from the patient's estate, payment will be made either to the estate representative or to a surviving member of the patient's immediate family. If someone other than the patient paid the bill, payment may be made to that person.

If the bill has not been paid and the doctor or supplier does not accept assignment, the medical insurance payment can be made to the person who has legal obligation to pay the bill for the deceased patient. The person can claim the medical insurance payment either before or after paying the bill.

The Medicare carrier or any Social Security office can provide additional information about how to claim a medical insurance payment after a patient dies.

TIME LIMITS

Under the law, there are some time limits for submitting medical insurance claims. For medical insurance to make payments on your claims, you must send in your claims within these time limits. You always have at least 15 months to submit claims. The table on page 27 tells you exactly what the time limits are.

For service you receive between	Your claim must be submitted by
Oct 1, 1987, & Sept. 30, 1988	Dec. 31, 1989
Oct 1, 1988, & Sept. 30, 1989	Dec. 31, 1990
Oct 1, 1989, & Sept. 30, 1990	Dec. 31, 1991

WHERE TO SEND YOUR CLAIMS

The list on pages 33 to 37 gives the names, addresses, and telephone numbers, by State, of the Medicare carriers selected to handle claims. To find out where to send your medical insurance claim, look in the list for the State where you received the services.

Under the name of the State, you will find the name of the carrier that will handle your claim. If there is more than one carrier in the State, look for the county where you received services to find the carrier that will handle your claim. (See page 24 to find out how to submit medical insurance claims.)

If you are not sure where to send your first claim and happen to send it to the wrong office, your claim will be sent to the right place.

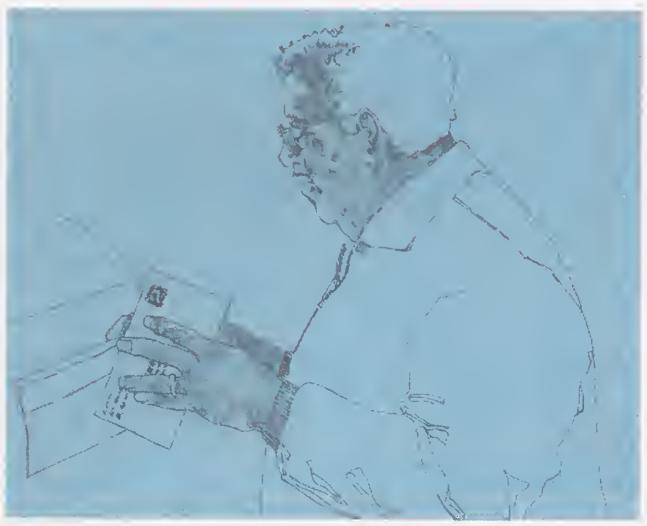
Whenever you send in a claim, be sure to include the word "Medicare" in the carrier's address on the envelope. Also, be sure to put your return address and a stamp on the envelope.

After you make a claim, the carrier will usually send you another 1490S form for your next claim. The form will usually show the carrier's name and address in the top right hand corner. If you ever need to file a medical insurance claim and don't have a claim form, you can use the one on page 29 or you can get one by phoning the Medicare carrier or a Social Security office.

NOTE: If you are entitled to Medicare under the Railroad Retirement system, send your medical insurance claims to The Travelers Insurance Company office which serves your region. Regional offices of The Travelers are listed in ***Your Medicare Handbook for Railroad Retirement Beneficiaries,*** which is available at any railroad retirement office.

FINANCIAL ASSISTANCE FOR LOW-INCOME BENEFICIARIES

The recently enacted Medicare Catastrophic Coverage Act of 1988 provides some limited assistance through Medicaid for paying your share of acute care costs under Medicare. You must not otherwise be eligible for Medicaid but must meet certain income and resource tests. If your annual income level is below the national poverty level ($5,770 for one person or $7,730 for a family of two, in January 1989) and you do not have access to many financial resources, you **may** qualify for government assistance in paying the Medicare premium, and at least some of the Medicare deductibles and copayments. The maximum annual income level for qualification may vary by State. If you qualify, this financial assistance will be offered through your State's medical assistance (Medicaid) program sometime after January 1, 1989. The date of availability will vary from State to State. If you think you may qualify, you should contact your State or local welfare, social service or public health agency.



[redacted]

FORM APPROVED
OMB NO. 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT—SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

SEND COMPLETED FORM TO:

1 Name of Beneficiary from Health Insurance Card
(Last) (First) (Middle)

2 Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐
(Street or P.O. Box — Include Apartment Number)
(City) (State) (Zip)

3b Telephone Number
(Include Area Code)
(___ ___ ___)
___ ___ ___ – ___ ___ ___ ___

4 Describe the Illness or Injury for which Patient Received Treatment

4b Was condition related to:
A. Patient's employment ☐ Yes ☐ No
B. Accident ☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

5 a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No

b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policy or Medical Assistance No.

Policyholders Name:

NOTE: If you DO NOT want payment information on this claim released, put an (X) here ☐

6 I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

HOW TO FILL OUT THIS MEDICARE FORM

Medicare will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill does not have to be paid before you submit this claim for payment, but you MUST attach an itemized bill in order for Medicare to process this claim.

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

Block 1. Print your name shown on your Medicare Card. (Last Name, First Name, Middle Name)

Block 2. Print your Health Insurance Claim Number including the letter at the end **exactly** as it is shown on your Medicare card. Check the appropriate box for the patient's sex.

Block 3. Furnish your mailing address and include your telephone number in Block 3b.

Block 4. Describe the illness or injury for which you received treatment. Check the appropriate box in Blocks 4b and 4c.

Block 5a. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where you are currently working.

Block 5b. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where your spouse is currently working.

Block 5c. Complete this Block if you have any medical coverage other than Medicare. Be sure to provide the Policy or Medical Assistance Number. You may check the box provided if you do not wish payment information from this claim released to your other insurer.

Block 6. Be sure to sign your name. If you cannot write your name, make an (X) mark. Then have a witness sign his or her name and address in Block 6 too.

If you are completing this form for another Medicare patient you should write (By) and sign your name and address in Block 6. You also should show your relationship to the patient and briefly explain why the patient cannot sign.

Block 6b. Print the date you completed this form.

B. Each itemized bill MUST show all of the following information:

- Date of each service
- Place of each service —Doctor's Office —Independent Laboratory —Outpatient Hospital —Nursing Home —Patient's Home —Inpatient Hospital
- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Doctor's or supplier's name and address. Many times a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTANT THE ONE WHO TREATED YOU BE IDENTIFIED. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is shown on the physician's bill. If not, be sure you have completed Block 4 of this form.
- Mark out any services on the bill(s) you are attaching for which you have already filed a Medicare claim.
- If the patient is deceased please contact your Social Security office for instructions on how to file a claim.
- Attach an Explanation of Medicare Benefits notice from the other insurer if you are also requesting Medicare payment.

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Health Care Financing Administration to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205 (a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

With one exception, which is discussed below, there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877 (a) (3) of the Social Security Act provides criminal penalties for withholding this information.

AN IMPORTANT MESSAGE FROM MEDICARE

YOUR RIGHTS WHILE YOU ARE A MEDICARE HOSPITAL PATIENT

- You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, **your discharge date must be determined solely by your medical needs**, not by "DRGs" or Medicare payments.

- You have the right to be fully informed about decisions affecting your Medicare coverage and payment for your hospital stay and for any post-hospital services.

- You have the right to request a review by a Peer Review Organization of any written Notice of Noncoverage that you receive from the hospital stating that Medicare will no longer pay for your hospital care. Peer Review Organizations (PROs) are groups of doctors who are paid by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients. The phone number and address of the PRO for your area are:

  _____

  _____

  _____

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. **If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post-hospital care, don't hesitate to ask your doctor.** The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

- Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "Notice of Noncoverage." You must have this Notice of Noncoverage if you wish to exercise your right to request a review by the PRO.

- The Notice of Noncoverage will state either that your doctor or the PRO agrees with the hospital's decision that Medicare will no longer pay for your hospital care.

  + If the hospital and your doctor agree, the PRO does not review your case before a Notice of Noncoverage is issued. But the PRO will respond to your request for a review of your Notice of Noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the PRO makes its decision, if you request the review by noon of the first work day after you receive the Notice of Noncoverage.

  + If the hospital and your doctor disagree, the hospital may request the PRO to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation the PRO must agree with the hospital or the hospital cannot issue a Notice of Noncoverage. You may request that the PRO reconsider your case after you receive a Notice of Noncoverage but since the PRO has already reviewed your case once, you may have to pay for **at least one day of hospital care** before the PRO completes this reconsideration.

IF YOU **DO NOT** REQUEST A REVIEW, **THE HOSPITAL MAY BILL YOU** FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE NOTICE OF NONCOVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDES YOU WITH A NOTICE OF NONCOVERAGE.

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

- If the Notice of Noncoverage states that your **physician agrees** with the hospital's decision:
  - + You must make your request for review to the PRO by **noon of the first work day** after you receive the Notice of Noncoverage by contacting the PRO by phone or in writing.
  - + The PRO must ask for your views about your case before making its decision. The PRO will inform you by phone and in writing of its decision on the review.
  - + If the PRO agrees with the Notice of Noncoverage, you may be billed for all costs of your stay beginning at noon of the day **after** you receive the PRO's decision.
  - + Thus, you will **not** be responsible for the cost of hospital care before you receive the PRO's decision.
- If the Notice of Noncoverage states that the **PRO agrees** with the hospital's decision:
  - + You should make your request for reconsideration to the PRO **immediately** upon receipt of the Notice of Noncoverage by contacting the PRO by phone or in writing.
  - + The PRO can take up to three working days from receipt of your request to complete the review. The PRO will inform you in writing of its decision on the review.
  - + Since the PRO has already reviewed your case once, prior to the issuance of the Notice of Noncoverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your Notice of Noncoverage **even if the PRO has not completed its review.**
  - + Thus, if the PRO continues to agree with the Notice of Noncoverage, **you may have to pay for at least one day of hospital care.**

NOTE: The process described above is called "immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of Medicare's decision to no longer pay for your care at any point during your hospital stay or after you have left the hospital. The Notice of Noncoverage will tell you how to request this review.

POST-HOSPITAL CARE

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. Medicare and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, patient representative and your family in making preparations for care after you leave the hospital. **Don't hesitate to ask questions.**

ACKNOWLEDGEMENT OF RECEIPT-My signature only acknowledges my receipt of this Message from (name of hospital) on (date) and does not waive any of my rights to request a review or make me liable for any payment.

_____

Signature of beneficiary or
person acting on behalf of beneficiary

MEDICARE CARRIERS

Note: The toll-free or 800 numbers listed below can be used only in the states or service areas indicated. Also listed are the local commercial numbers for some carriers.

ALABAMA
Medicare/Blue Cross-Blue Shield of Alabama
P.O. Box C-140 Birmingham, Alabama 35283
1-800-292-8855
205-988-2244

ALASKA
Medicare/Aetna Life & Casualty
200 S.W. Market St., P.O. Box 1998
Portland, Oregon 97207-1998
1-800-547-6333

ARIZONA
Medicare/Aetna Life & Casualty
P.O. Box 37200
Phoenix, Arizona 85069
1-800-352-0411
602-861-1968

ARKANSAS
Medicare/Arkansas Blue Cross and
Blue Shield
A Mutual Insurance Company
P.O. Box 1418, Little Rock, Arkansas 72203
1-800-482-5525
501-378-2320

CALIFORNIA
Counties of: Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, Santa Barbara
Medicare/Transamerica Occidental
Life Insurance Co.
Box 50061
Upland, California 91785-0061
1-800-252-9020
213-748-2311
Rest of State: Medicare Claims Dept.
Blue Shield of California
Chico, California 95976
(In area codes 209, 408,415, 707, 916)
1-800-952-8627
916-743-1583
(In area codes 213, 619, 714, 805, 818)
1-800-848-7713
714-824-0900

COLORADO
Medicare/Blue Shield of Colorado
700 Broadway, Denver, Colorado 80273
1-800-332-6681
303-831-2661

CONNECTICUT
Medicare/The Travelers Ins. Co.
P.O. Box 5005
Wallingford, Connecticut 06493-5005
1-800-982-6819
(In Hartford) 203-728-6783

DELAWARE
Medicare/Pennsylvania Blue Shield
P.O. Box 65, Camp Hill, Pennsylvania 17011
1-800-851-3535

DISTRICT OF COLUMBIA
Medicare/Pennsylvania Blue Shield
P.O. Box 100, Camp Hill, Pennsylvania 17011
1-800-233-1124

FLORIDA
Medicare/Blue Shield of Florida, Inc.
P.O. Box 2525, Jacksonville, Florida 32231
1-800-333-7586
904-355-3680

GEORGIA
Medicare/Aetna Life & Casualty
P.O. Box 3018
Savannah, Georgia 31402-3018
1-800-727-0827
912-927-0934

HAWAII
Medicare/Aetna Life & Casualty
P.O. Box 3947, Honolulu, Hawaii 96812
1-800-272-5242
808-524-1240

IDAHO
EQUICOR, Inc.
P.O. Box 8048, Boise, Idaho 83707
1-800-632-6574
208-342-7763

ILLINOIS
Medicare Claims
Blue Cross & Blue Shield of Illinois
P.O. Box 4422
Marion, Illinois 62959
1-800-642-6930
312-938-8000

INDIANA
Medicare Part B
Associated Ins. Companies, Inc.
P.O. Box 7073
Indianapolis, Indiana 46207
1-800-622-4792
317-842-4151

IOWA
Medicare/Blue Shield of Iowa
636 Grand, Des Moines, Iowa 50309
1-800-532-1285
515-245-4785

KANSAS
Counties of: Johnson, Wyandotte
Medicare/Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141
1-800-892-5900
816-561-0900
Rest of State: Medicare/Blue Shield of Kansas
P.O. Box 239, Topeka, Kansas 66601
1-800-432-3531
913-232-3773

KENTUCKY
Medicare-Part B
Blue Cross & Blue Shield of Kentucky
100 East Vine St.
Lexington, Kentucky 40507
1-800-432-9255
606-233-1441

LOUISIANA
Blue Cross & Blue Shield of
Louisiana Medicare Administration
P.O. Box 95024
Baton Rouge, Louisiana 70895-9024
1-800-462-9666
(In New Orleans) 504-529-1494
(In Baton Rouge) 504-272-1242

MAINE
Medicare/Blue Shield of
Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005
1-800-492-0919

MARYLAND
Counties of: Montgomery, Prince Georges
Medicare/Pennsylvania Blue Shield
P.O. Box 100
Camp Hill, Pennsylvania 17011
1-800-233-1124
Rest of State: Maryland Blue Shield, Inc.
700 E. Joppa Road
Towson, Maryland 21204
1-800-492-4795
301-561-4160

MASSACHUSETTS
Medicare/Blue Shield of Massachusetts, Inc.
55 Accord Park Drive
Rockland, Massachusetts 02371
1-800-882-1228

MICHIGAN
Medicare Part B
Michigan Blue Cross & Blue Shield
P.O. Box 2201, Detroit, Michigan 48231-2201
(In area code 313) 1-800-482-4045
(In area code 517) 1-800-322-0607
(In area code 616) 1-800-442-8020
(In area code 906) 1-800-562-7802
(In Detroit) 313-225-8200

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Medicare/The Travelers Ins. Co.
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South Bloomington, Minnesota 55431
1-800-352-2762
612-884-7171
Rest of State: Medicare
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1-800-392-0343
612-456-5070

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601-956-0372

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816-561-0900
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General American Life Insurance Co.
P.O. Box 505, St. Louis, Missouri 63166
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P.O. Box 3106, Omaha, Nebraska 68103-0106
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1-800-528-0311

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Medicare
Blue Shield of Massachusetts/Tri-State
P.O. Box 1010
Biddeford, Maine 04005
1-800-447-1142

NEW JERSEY
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Harrisburg, Pennsylvania 17140-0010
1-800-462-9360

NEW MEXICO
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1-800-423-2925
(In Albuquerque) 505-843-7771

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212-490-4444
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Medicare/Empire Blue Cross & Blue Shield
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1-800-442-8430
County of: Queens
Medicare/Group Health, Inc.
P.O. Box A966, Times Square Station
New York, New York 10036
212-760-6790
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Binghamton, New York 13902-0600
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Medicare/Nationwide Mutual Ins. Co.
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614-249-7157

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Salt Lake City, Utah 84130-0269
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801-481-6196

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Cities of: Alexandria, Falls Church, Fairax
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Rest of State: Medicare/The Travelers Ins. Co.
P.O. Box 26463, Richmond, Virginia 23261
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804-254-4130

WASHINGTON
Medicare/Washington Physicians' Service
Mail to your local Medical Service Bureau.
If you do not know which bureau handles your claim, mail to:
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(In King County) 1-800-422-4087
(206) 464-3711
(In Spokane) 1-800-572-5256
(509) 536-4550
(In Kitsap) 1-800-552-7114
(206) 377-5576
(In Pierce) (206) 597-6530
Others: Collect if out of call area.

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(In Milwaukee) 414-931-1071

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Cheyenne, Wyoming 82003
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Medicare/Seguros De Servicio De
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137-800-462-2970
809-759-9191

GLOSSARY OF MEDICARE-RELATED TERMS

actual charge—the amount a physician or supplier actually bills a patient for a particular medical service or supply. (This may differ from the customary, prevailing, and/or reasonable charges under Medicare.)

assignment—a process through which a doctor or supplier agrees to accept the Medicare program's payment as payment in full except for specific coinsurance and deductible amounts required of the patient.

carrier—a private insurance organization which contracts with the Federal government to handle claims from doctors and suppliers of services covered by Medicare medical insurance.

claim—a request to a carrier or intermediary by a beneficiary or a provider acting on behalf of a beneficiary for payment of benefits under Medicare.

coinsurance—a cost-sharing requirement which provides that a beneficiary will assume a portion or percentage of the costs of covered services.

competitive medical plan (CMP)—a prepayment health care plan. CMPs with Medicare contracts offer Medicare beneficiaries all services covered by fee-for-service Medicare.

customary charge—the amount which a doctor or supplier most frequently charges for each separate service and supply furnished.

deductible—the amount of expense a beneficiary must first incur before Medicare begins payment for covered services.

health maintenance organization (HMO)—a prepayment health care plan. HMOs with Medicare contracts offer Medicare beneficiaries all services covered by fee-for-service Medicare.

home health agency—a public or private organization that specializes in giving skilled nursing services and other therapeutic services such as physical therapy in a beneficiary's home.

hospice—a program operated by a public agency or private organization which engages primarily in providing pain relief, symptom management, and supportive services for terminally ill people and their families.

hospital insurance—the part of Medicare which helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care, and hospice care.

intermediary—a private insurance organization which contracts with the Federal government to handle Medicare payment for services by hospitals, skilled nursing facilities, and home health agencies paid through the hospital insurance program.

medical insurance—the part of Medicare which helps pay for medically necessary doctors' services, outpatient hospital services, and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare as well as some home health services.

medigap policy—private health insurance designed to supplement Medicare.

outpatient facility—a facility designed to provide health and medical services to individuals who are not inpatients.

participating physician or supplier—a physician or supplier who agrees to accept assignment on all Medicare claims.

peer review organizations (PROs)—groups of practicing doctors and other health care professionals under contract to the Federal government to review the care provided to Medicare patients.

prepayment health plans—health care providers such as Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs).

prevailing charge—based upon the customary charges for covered medical insurance services or items, the prevailing charge is the maximum charge Medicare can approve for any item or service.

prospective payment system—a process started in 1983 under which hospitals are paid fixed amounts based on the principal diagnosis for each Medicare hospital stay.

Quality Review Organizations (QROs)—groups of practicing doctors and other health care professionals under contract to the Federal goverment to review the care provided to Medicare patients.

reasonable charges—amounts approved by the Medicare carrier which will be either the customary charge, the prevailing charge, or the actual charge, whichever is the lowest.

skilled nursing facility—a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services.

supplemental health insurance—also called "Medigap" insurance—private health insurance designed to fill some of the gaps in Medicare.

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